Reset Form

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance

Request and Justification for Continuous Skilled Nursing Services

I. General Information

Personal Information

Recipient's Name: _____

Recipient's ID Number: _____ Category of Assistance: _____

Date of Birth: _____ Telephone Number: _____

Weight: _____ Height: _____

Primary Medical Diagnosis: _____

Secondary Medical Diagnoses: _____

_____

Other Insurance Information

The Division is the payer of last resort. The provider should use diligent efforts to obtain coverage from other insurance sources.

Private Insurance Carrier: _____

Policyholder's Name: _____

Policy Number: _____

Group Number: _____

Why is this service not covered under this insurance? _____

_____

Has this insurance carrier changed since the last prior authorization request? ☐ Yes ☐ No

Household Information

Primary Caregivers: _____ Relationship: _____

_____ Relationship: _____

Has there been any change in the recipient's status that requires additional training of the primary caregivers? If so, please be specific.

_____

_____

Are there other recipients in the home who also receive continuous skilled nursing services? If so, list the names of the recipients, the number of hours per calendar week, and the home health agency involved.

_____

_____

_____

II. Patient Assessment

Describe in detail the recipient's developmental status and ability to perform activites of daily living.

_____

_____

_____

_____

_____

Important: You must complete the following section before proceeding to the Plan of Care.

Care Provided by School System (Mandatory Entry)
Is the recipient receiving or scheduled to receive any continuous skilled nursing services at school during this prior-authorization period that is paid for by the school system? ☐ **Yes** ☐ **No** If **no,** complete Plan of Care I on page 3. If **yes,** complete Plan of Care II on pages 4 and 5. For the plan of care that you will be completing, you must list only skilled nursing interventions that require a licensed nurse. These skilled nursing interventions must indicate a specific frequency and must not be expressed as "prn," "see attached," or "as ordered."

Plan of Care I

(Complete this section ***only*** if the recipient is ***not receiving*** continuous skilled nursing services that are paid for by the school system.)

Provide a plan of care based on a 24-hour-a-day, seven-day calendar week. List only skilled nursing interventions that require a licensed nurse. Indicate a specific frequency (not "prn," "see attached," or "as needed").

Skilled Intervention	Frequency per Day

Total number of hours being requested: _____

Plan of Care II

(Complete all three items of Plan of Care II ***only*** if the recipient is receiving continuous skilled nursing services at school that are paid for by the school system.)

1. List how many hours of continuous skilled nursing services per school day that the school system pays for.

Monday	Tuesday	Wednesday	Thursday	Friday

2. For each day the recipient attends school in a calendar week, provide a plan of care based solely on the total number of hours **outside** of those identified as being paid for by a school system. List only skilled nursing interventions that require a licensed nurse. Indicate a specific frequency (not "prn," "see attached," or "as needed").

Skilled Intervention	**Frequency per Day**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

No. of hours: _____ x No. of days: _____ = Total # of hours: _____

(Note: Complete page 5 only if using Plan of Care II.)

Plan of Care II (cont.)

3. For each day the recipient does not attend school in a calendar week, provide a plan of care based on a 24-hour day.

Skilled Intervention	Frequency per Day

No. of hours: _____ x No. of days: _____ = Total # of hours: _____

Total number of hours per calendar week being requested. (Sum total of items 2 and 3): _____

III. Medications

List all prescription and nonprescription medications. **You must document the actual use of PRN medications.** Attach a separate page if you need more space to document all medications.

Medication, Dosage, and Route Administered	Frequency/Actual Use
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IV. Equipment/Supplies

For all items listed, indicate if they are required in this recipient's care. If equipment or supplies are required, **you must indicate the actual use of equipment**.

Equipment	Yes	No	Frequency of Use
Tracheostomy Tubes	☐	☐	_____
Suction Machine	☐	☐	_____
Ventilator (type): _____	☐	☐	_____
Mist	☐	☐	_____
Oxygen	☐	☐	_____
Ambu Bag	☐	☐	_____
Nebulizer	☐	☐	_____
Gastrostomy Tubes	☐	☐	_____
Pump/Supplies	☐	☐	_____
Nasogastric Tubes	☐	☐	_____
Oxymeter	☐	☐	_____
Cardiac/Apnea Monitor	☐	☐	_____
Catheter (type): _____	☐	☐	_____
Ostomy Supplies	☐	☐	_____
I.V. Equipment (type): _____	☐	☐	_____

V. Nursing Progress and Summary Notes

If applicable, include an updated summary of the past prior-authorization period. Document any change in the recipient's medical status, including inpatient and/or outpatient hospital visits, frequency of illnesses, changes in plan of care, and calls or visits to the recipient's physician.

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_____

_____

_____

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_____

VI. Health-Related Services Currently Provided to the Recipient

Check all services used by the recipient. Indicate the frequency and payer.

Service	Yes	No	Frequency and Payer
Physical Therapy	☐	☐	_____
Occupational Therapy	☐	☐	_____
Speech/Language Therapy	☐	☐	_____
Intermittent Skilled Nursing Visits	☐	☐	_____
Home Health Aide	☐	☐	_____
Personal Care Attendant	☐	☐	_____
Children's Medical Day Care	☐	☐	_____
Adult Day Health	☐	☐	_____
Hospice	☐	☐	_____
Other	☐	☐	_____

If the recipient has a third-party insurance, indicate why the primary insurer is not covering the services used by the recipient in Section VI. List the name and telephone number of the insurance case manager.

_____

_____

_____

VII. Services Provided by Other Agencies

If applicable, list services (including respite and case management) being provided by other sources such as the Massachusetts Commission for the Blind, the Department of Public Health, the Department of Social Services, the Department of Education, the Department of Mental Health, the Department of Mental Retardation, and an early intervention program. Indicate the frequency of service and the name and telephone number of the case manager.

_____

_____

_____

VIII. Request for Continuous Skilled Nursing

Total number of hours per calendar week being requested: _____

Current Prior Authorization Number (if applicable): _____ Expiration Date: _____

Number of hours authorized per week: _____

IX. Names and Signatures

Home Health Agency Name: _____

Address: _____

Telephone Number: _____

Nurse from Home Health Agency or Independent Nurse

Name: _____ Telephone No.: _____

Signature: _____ Date: _____

Physician's Name: _____ Telephone No.: _____

Signature: _____ Date: _____

Primary Caregiver's Name (optional): _____

Signature: _____ Date: _____